



**CONTRA COSTA ONCOLOGY**  
Specializing in Cancer Care and Blood Disorders

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# RECORDS RELEASE AUTHORIZATION

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB \_\_\_\_\_

I AUTHORIZE MY MEDICAL RECORDS, CONCERNING MY ILLNESS AND/OR TREATMENT, TO BE SENT TO:

Contra Costa Oncology  
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Fax: (925) 939-9630

PATIENT SIGNATURE: \_\_\_\_\_

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